VIReC | VA INFORMATION RESOURCE CENTER

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Department of Veterans Affairs

REQUEST FOR PATIENT LEVEL DATA

PRIVACY STATEMENT: It is the policy of VIReC to protect the patient's rights of confidentiality. The requestor, in exchange for receipt of patient level data records, agrees to use the data only as described and for the purpose(s) set forth in this request. The requestor further agrees to provide a secure environment for storage and use of the source data and any working files to prevent unauthorized access. Except as specified in the attached request, or as later approved, the requestor agrees not to release, share or further distribute these records and not to release, share or distribute any data containing complete or partial patient records. The requestor will comply with all laws, regulations and VA/VHA policies relating to privacy of patient information.

1. PRINCIPAL INVESTIGATOR

A. NAME *(Last, First, M.I.)*:

B. POSITION TITLE:	**C. ORGANIZATION:**
D. VA SERVICE:	**E. VA FACILITY NAME AND STATION NUMBER:**

F. ADDRESS:

G. PHONE NUMBER:	**H. FAX:**	**I. E-MAIL ADDRESS:**

2. CONTACT PERSON

A. NAME *(Last, First, M.I.)* :

B. POSITION TITLE:	**C. ORGANIZATION:**

D. ADDRESS:

E. TELEPHONE NUMBER:	**F. FAX:**	**G. E-MAIL ADDRESS:**

3. PROJECT INFORMATION

A. NAME OF PROJECT:

B. PLEASE WRITE A ONE OR TWO SENTENCE DESCRIPTION OF YOUR PROJECT:

4. INDIVIDUALLY IDENTIFIABLE PATIENT DATA

A. ARE YOU REQUESTING DATA WITH PATIENT IDENTIFIERS? ☐ **YES** ☐ **NO**

PLEASE SPECIFY. ☐ **SSN** ☐ **SCRAMBLED SSN** ☐ **HIC (Medicare's Health Insurance Claim Account Number)**

YOU MUST HAVE IRB APPROVAL FOR YOUR REQUESTED IDENTIFIER(S) AND ALL PHI.

YOU MUST HAVE APPROVAL OF THE OFFICE OF RESEARCH AND DEVELOPMENT (ORD) FOR SSNs.

B. FOR ALL REQUESTED IDENTIFIERS AND PHI, YOU HAVE: ☐ **SIGNED CONSENT FORMS**

☐ **AN IRB APPROVED WAIVER OF AUTHORIZATION**

5. COHORT DEFINITION AND MATCH CRITERIA

A. ARE YOU:

- ☐ PROVIDING VIREC WITH YOUR PREVIOUSLY DEFINED COHORT (COMPLETE PART B)
- ☐ REQUESTING THAT VIREC GENERATE YOUR COHORT FROM MEDICARE FILES (COMPLETE PART C)
- ☐ BOTH (COMPLETE PARTS B AND C)
- ☐ OTHER (Please specify)

B. PREVIOUSLY DEFINED COHORT

APPROXIMATE NUMBER IN COHORT:

Please indicate which identifier you will provide VIReC for matching to Medicare files:

☐ SSN ☐ SCRAMBLED SSN ☐ HIC (Medicare's Health Insurance Claim Account Number)

Medium for the finder file: ☐ SAS file ☐ text file ☐ Excel ☐ Other (Please specify)_____

C. VIREC GENERATED COHORT

APPROXIMATE NUMBER EXPECTED IN COHORT:

Please describe in detail what selection criteria should be used to generate your cohort. Selection criteria may include demographic variables (age, race, sex, residence, etc.), clinical variables (diagnosis codes, procedure codes, DRGs, etc.), geographic variables (state, county, zip code), and time frames. Specify which Medicare files and variables should be used to generate your cohort.

6. DATA REQUESTED

A. FILE EXTRACTS FOR COHORT

Please select from the following Calendar Years:

1999	2000	2001	2002	
☐	☐	☐	■	Medicare Provider and Analysis Review File (MedPAR)
☐	☐	☐	■	Skilled Nursing Facility SAF
☐	☐	☐	■	Home Health SAF
☐	☐	☐	■	Hospice SAF
☐	☐	☐	■	Outpatient SAF
☐	☐	☐	■	Carrier SAF
☐	☐	☐	■	Durable Medical Equipment SAF
☐	☐	☐	■	Denominator
☐	■	■	■	Vital Status
■	■	☐	■	Provider of Service (POS)
☐	☐	■	■	Group Health Plan (GHP)

B. MEDIUM AND FORMAT
Indicate the one medium and one format in which you would like to receive data.

MEDIUM
- ☐ **CD ROM**
- ☐ **DVD ROM**
- ☐ **DLT TAPES**
- ☐ **IBM CARTRIDGE**

FORMAT
- ☐ **SAS**
- ☐ **SAS TRANSPORT**
- ☐ **OTHER (Please specify)**

C. PLEASE SPECIFY ANY OTHER INFORMATION YOU WOULD LIKE VIReC TO KNOW ABOUT YOUR REQUEST.

7. SUBMISSION

A. NAME OF PERSON COMPLETING THIS FORM *(Last, First, M.I.)*:

B. I AGREE TO PROVIDE VIREC WITH:

1. **A COPY OF THE PUBLISHED RESEARCH PAPER, AND**
2. **FEEDBACK REGARDING MEDICARE FILES USED AND THE QUALITY OF THE VARIABLES USED.**

C. SIGNATURE OF PRINCIPAL INVESTIGATOR:	**D. DATE** *(MM/DD/YYYY)*

E. SUBMIT THE FOLLOWING ITEMS:
1. **COMPLETED, SIGNED REQUEST FORM**
2. **YOUR IRB APPROVED RESEARCH PROPOSAL PACKAGE**
3. **IRB PROTOCOL AND APPROVAL LETTER**
4. **DATA SECURITY PLAN AS REVIEWED AND APPROVED BY THE IRB**
5. **R&D APPROVAL LETTER**

Send this information to:

Carolyn O'Leary, R.N., B.S.
Project Manager

Fax: (708) 202-2415

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Hines, IL 60141

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